tween circumcision and sexually transmitted disease is far from determined.[3] Even if the relationship is proved, however, future sexually transmitted diseases are unlikely to have a major effect on the circumcision controversy because of discounting. Discounting is a procedure widely accepted as necessary when dealing with future health outcomes.[5] For example, assuming a discount rate of 5% (half that proposed by the US Office of Technology Assessment[6]), a 40% increase of sexually transmitted diseases in uncircumcised men has the quality-adjusted health effect of about half a well day 25 years in the future. This is hardly an argument for routine circumcision. The possible effect of circumcision on the transmission of the acquired immunodeficiency syndrome (AIDS) virus is, of course, difficult to estimate. AIDS is unlikely to be an issue for a child born in 1989 until at least the year 2005, and we have no idea what the epidemiology of AIDS will be 16 years from now.

A journal of substance should have higher standards than to allow one person's thoughts to run unopposed against careful, scholarly, peer-reviewed work. We hope this example is a momentary editorial lapse rather than a new editorial direction.

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EDITOR'S NOTE:

We appreciate the authors' careful reading of the journal and their thoughtful response.

MSMW

Acute Severe Asthma

TO THE EDITOR: There is an obvious omission in the article by Dr Franklin in the May issue.[1] No review of asthma is complete without mention of preventing attacks. An obese, smoking, beer-drinking person sleeping on feather pillows with a cat should be told that this behavior may have something to do with his or her asthma. Until this is done, the acute severe asthma is liable to continue.

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Treating Septic Prepatellar Bursitis

TO THE EDITOR: We congratulate McAfee and Smith[1] for their excellent review of a problem that we treat commonly: olecranon and prepatellar bursitis. Our institution provides medical care for a large population of active duty sailors and marines who often work on their knees and are predisposed to developing septic prepatellar bursitis. We also agree with McAfee and Smith's statements that blunt trauma, skin abrasion, or repetitive pressure applied to the knee may precipitate septic bursitis by inoculating the prepatellar space with *Staphylococcus aureus.* We take issue, however, with their claim that surgical incision and drainage are rarely necessary and may prolong the healing time.

Report of a Case

A 22-year-old sailor was referred by his ship's medical officer with a low-grade fever and anterior left knee pain that was unresponsive to a seven-day course of oral antibiotics and rest. On physical examination, the prepatellar soft tissues were swollen, red, and exquisitely tender; joint motion was painless except with full flexion, which compressed the prepatellar bursae. Needle aspiration yielded 5 ml of purulent fluid. The patient underwent surgical irrigation and debridement of the bursa through a 2.5-cm (1-in) lateral para-

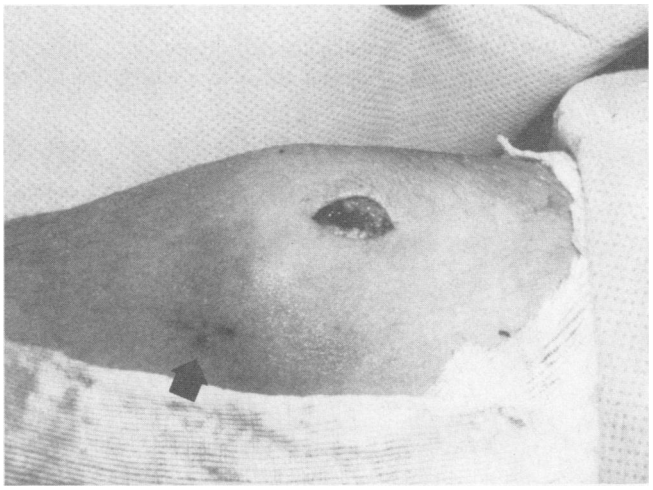

Figure 1.—The surgical incision for irrigation and drainage is shown. There are also skin abrasions **(arrow)**.

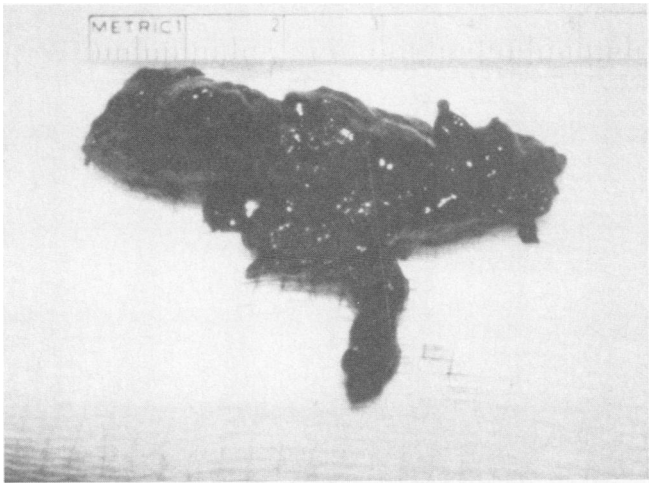

Figure 2.—The specimen shows infected clot and the posterior wall of the bursa.

patellar incision using leg block anesthesia (Figure 1). In addition to further purulent fluid in the cavity, a large clot of infected necrotic bursal tissue was seen and excised from the posterior wall of the bursa (Figure 2).

Nylon sutures were placed in the skin but left untied. The wound was loosely wicked open with sterile gauze soaked in saline solution. Cultures showed a growth of *S aureus,* and the patient was treated with a five-day course of intravenous cefazolin sodium and twice-a-day whirlpool baths and dressing changes. The wound was closed on the sixth postoperative day by tying the previously placed sutures. An additional ten-day course of oral dicloxacillin was given, and the patient was discharged on hospital day 8. He healed without complication.

Discussion

Wilson-MacDonald reported that 3 of 27 patients (11%) with septic prepatellar bursitis failed repeated needle aspiration and intravenous antibiotic treatment and required surgical drainage.[2] In addition, he reported 6 patients treated initially with surgical drainage; all 9 surgical incisions healed uneventfully. Thompson and co-workers, on the other hand, reported that 2 of 5 surgically treated cases still had draining incisions at discharge. They did not report the duration of hospital stay, length of incision, or method of wound closure, however.[3]

We have no experience with Knight and colleagues' method of percutaneous placement of a suction-irrigation system using local antibiotic solution.[4] Injecting antibiotics into the bursal space has no documented efficacy for bacterial septic bursitis, however,[1] and a complicated inflow-outflow tube system provides no advantages over a simple, thorough irrigation and debridement through a small, well-placed incision. In addition, a surgical procedure may be necessary to treat secondary osteomyelitis[5] or fungal septic bursitis.[6]

In summary, when aspiration fails or when a pointing abscess exists, incision and drainage of the bursa are indicated.

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The views expressed in this letter are those of the authors and do not reflect the official policy or position of the Department of the Navy, Department of Defense, or the US Government.